

Facility Name & ID Number MANORCARE OF HIGHLAND PARK# 0045369 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>215</u>	Skilled (SNF)	<u>215</u>	<u>78,475</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>215</u>	TOTALS	<u>215</u>	<u>78,475</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,135</u>	<u>8,623</u>	<u>8,185</u>	<u>26,943</u>	8
9	SNF/PED					9
10	ICF	<u>3,108</u>	<u>334</u>	<u>0</u>	<u>3,442</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,243</u>	<u>8,957</u>	<u>8,185</u>	<u>30,385</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 38.72%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 3/10/97

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/15/01 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 208 and days of care provided 6,622Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number MANORCARE OF HIGHLAND PARK # 0045369 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	262,973	12,281	145	275,399	2,370	277,769		277,769		1
2	Food Purchase		127,412		127,412		127,412	(1,164)	126,248		2
3	Housekeeping	127,650	14,461	258	142,369		142,369		142,369		3
4	Laundry	23,261	6,532	1,713	31,506		31,506		31,506		4
5	Heat and Other Utilities			191,562	191,562	8,638	200,200	(180)	200,020		5
6	Maintenance	41,613	13,612	78,000	133,225		133,225		133,225		6
7	Other (specify):* Med Waste			2,184	2,184		2,184		2,184		7
8	TOTAL General Services	455,497	174,298	273,862	903,657	11,008	914,665	(1,344)	913,321		8
	B. Health Care and Programs										
9	Medical Director			19,042	19,042		19,042		19,042		9
10	Nursing and Medical Records	1,733,062	130,978	91,475	1,955,515	50,955	2,006,470	(4,869)	2,001,601		10
10a	Therapy	331,209	8,669	87,107	426,985		426,985		426,985		10a
11	Activities	95,916	3,800	2,375	102,091		102,091		102,091		11
12	Social Services	74,059			74,059		74,059		74,059		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,234,246	143,447	199,999	2,577,692	50,955	2,628,647	(4,869)	2,623,778		16
	C. General Administration										
17	Administrative	98,255		415,093	513,348	(141,606)	371,742		371,742		17
18	Directors Fees										18
19	Professional Services			12,233	12,233	(8,982)	3,251	(3,251)			19
20	Dues, Fees, Subscriptions & Promotions			81,046	81,046		81,046	(18,047)	62,999		20
21	Clerical & General Office Expenses	299,647	47,445	(87,125)	259,967		259,967	113,869	373,836		21
22	Employee Benefits & Payroll Taxes			535,639	535,639	57,478	593,117		593,117		22
23	Inservice Training & Education			3,119	3,119		3,119		3,119		23
24	Travel and Seminar			9,593	9,593		9,593		9,593		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			136,750	136,750		136,750		136,750		26
27	Other (specify):*										27
28	TOTAL General Administration	397,902	47,445	1,106,348	1,551,695	(93,110)	1,458,585	92,571	1,551,156		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,087,645	365,190	1,580,209	5,033,044	(31,147)	5,001,897	86,358	5,088,255		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number **MANORCARE OF HIGHLAND PARK** #0045369 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			198,818	198,818	31,147	229,965		229,965			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,397	88,397		88,397		88,397			32
33	Real Estate Taxes			188,891	188,891		188,891	630	189,521			33
34	Rent-Facility & Grounds			1,150,000	1,150,000		1,150,000		1,150,000			34
35	Rent-Equipment & Vehicles			36,850	36,850		36,850		36,850			35
36	Other (specify):*											36
37	TOTAL Ownership			1,662,956	1,662,956	31,147	1,694,103	630	1,694,733			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,825	25,328	170,153		170,153		170,153			39
40	Barber and Beauty Shops			19,749	19,749		19,749		19,749			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):*		27,655		27,655		27,655		27,655			43
44	TOTAL Special Cost Centers		172,480	162,790	335,270		335,270		335,270			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,087,645	537,670	3,405,955	7,031,270		7,031,270	86,988	7,118,258			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **MANORCARE OF HIGHLAND PARK**# **0045369**Report Period Beginning: **01/01/03**Ending: **12/31/03****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		¹ Amount	² Refer- ence	³ OHF USE ONLY	
1	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(543)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,030)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,896)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,029)	21		13
14	Non-Care Related Interest	(1,417)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(576)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,251)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	132,817	21		24
25	Fund Raising, Advertising and Promotional	(18,047)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	630	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(5,670)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 86,988		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		¹ Amount	² Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 86,988		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		¹ Yes	² No	³ Amount	⁴ Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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MANORCARE OF HIGHLAND PARK

Page 5A

ID# 0045369
Report Period Beginning: 01/01/03
Ending: 12/31/03

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Cable TV	\$ (180)	5	1
2	Vending (Offset between Revenue & Expense)	(621)	2	2
3	Medical Transportation	(4,869)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,670)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MANORCARE OF HIGHLAND PARK# 0045369

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,164)	0	0	0	0	0	0	0	0	0	0	(1,164)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(180)	0	0	0	0	0	0	0	0	0	0	(180)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,344)	0	0	0	0	0	0	0	0	0	0	(1,344)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,869)	0	0	0	0	0	0	0	0	0	0	(4,869)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,869)	0	0	0	0	0	0	0	0	0	0	(4,869)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,251)	0	0	0	0	0	0	0	0	0	0	(3,251)	19
20	Fees, Subscriptions & Promotions	(18,047)	0	0	0	0	0	0	0	0	0	0	(18,047)	20
21	Clerical & General Office Expenses	113,869	0	0	0	0	0	0	0	0	0	0	113,869	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	92,571	0	0	0	0	0	0	0	0	0	0	92,571	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	86,358	0	0	0	0	0	0	0	0	0	0	86,358	29

Summary B

Facility Name & ID Number	MANORCARE OF HIGHLAND PARK	#	0045369	Report Period Beginning:	01/01/03	Ending:	12/31/03
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	100	Health Care & Retirement Corporation of America	Toledo, OH			
Manor Care, Inc.		(See H.O Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	Home Office Allocation	\$ 415,093	HCR Manor Care, Inc.	100.00%	\$ 415,093	\$
2	V	Page						1
3	V	8						2
4	V							3
5	V							4
6	V	10a	Therapy Management	13,457	Heartland Management Services	100.00%	13,457	5
7	V							6
8	V							7
9	V							8
10	V							9
11	V							10
12	V							11
13	V							12
14	Total		\$ 428,550			\$ 428,550	\$ *	13
								14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MANORCARE OF HIGHLAND PARK # 0045369 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MANORCARE OF HIGHLAND PARK # 0045369 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH. 43604
 Phone Number (419)252-5500
 Fax Number (419)254-5494

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	\$	\$	7,211,915	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	940,169	509,589	7,211,915	2,370	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	288,728		7,211,915	867	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	3,082,391		7,211,915	7,771	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	11,758,547	7,451,541	7,211,915	35,290	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	6,213,378	3,630,890	7,211,915	15,665	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	17,137,345	15,146,077	7,211,915	51,433	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	84,513,196	36,356,102	7,211,915	213,072	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	4,283,731		7,211,915	12,856	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	17,698,741		7,211,915	44,622	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.			7,211,915	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	12,354,014		7,211,915	31,147	12
13										13
14	32	Interest				11,412,188				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 169,682,428	\$ 63,094,199		\$ 415,093	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America *		X	Facility			\$ 1,733,736	\$			\$ 11,168	1	
2	* Note was paid off in current year											2	
3	National City Bank, Trustee		X	Finance Capital Additions				1,733,736			77,229	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,733,736	\$ 1,733,736			\$ 88,397	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,733,736	\$ 1,733,736			\$ 88,397	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MANORCARE OF HIGHLAND PARK COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0045369

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>16-16-401-005</u>	<u>See Attached</u>	\$ <u>188,891</u>	\$ <u>188,891</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>188,891.00</u>	\$ <u>188,891.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,108

B. General Construction Type: Exterior Masonary Frame Steel, Fire Resistant Number of Stories 3

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).
 N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	N/A			\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		2001		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)										
10	Civil Engineering Services		2001		3,332	127,623		127,623		135,057	9
11	Title survey, environmental site assessment,professional serv.		2001		26,933						10
12	Title survey, environmental site assessment,professional serv.		2001		5,937						11
13	Title survey, environmental site assessment,professional serv.		2001		11,541						12
14	Signage		2001		2,234						13
15	Signage		2002		10,967						14
16	Sidewalk		2003		3,496						15
17	Architect & Engineering Fees		2003		78,456						16
18	Developers Costs - Auto & Travel		2003		433						17
19	Developers Costs - Permits Fees		2003		1,195						18
20	Developers Costs - Plan Reviews		2003		6,013						19
21	Developers Costs - Overhead		2003		942,605						20
22	Interest		2003		83,525						21
23	Carpeting & Pads		2003		82,366						22
24	Wallcovering		2003		44,992						23
25	Cubicle Track - Material		2003		240						24
26	Carpentry Subcontractor		2003		905,757						25
27	HVAC		2003		4,180						26
28	Basic Electrical		2003		10,021						27
29	Building Demolition		2003		65,000						28
30	Site Clearing		2003		45,230						29
31	General Contractor		2003		324						30
32	Paving		2003		8,989						31
33	Landscaping		2003		31,494						32
34	Exterior Sign - Site		2003		583						33
35	Legal Fees		2003		44,751						34
36											35

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38	VWC	2003	75						38
39	Freight on Carpet	2003	43						39
40	Carpet	2003	359						40
41	Flooring Installation	2003	843						41
42	Architect & Engineering	2003	471						42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,422,385	\$ 127,623		\$ 127,623	\$	\$ 135,057	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 301,557	\$ 71,195	\$ 71,195	\$		\$ 125,175	71
72	Current Year Purchases	558,977						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			31,147	31,147			74
75	TOTALS	\$ 860,534	\$ 71,195	\$ 102,342	\$ 31,147		\$ 125,175	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,282,919	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 198,818	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,965	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,147	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 260,232	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **Highland Park Convalescent Center Associates**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1997	215	6/15/01	\$ 1,150,000	15	10	3
4	Additions							4
5								5
6								6
7	TOTAL		215		\$ 1,150,000			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☒ YES ☐ NO Terms: **(See Attached)** *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ **36,850** Description: **02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.**
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning **6/15/01**

Ending **6/15/16**

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **12/2002** \$ **1,150,000**

13. **12/2003** \$ **1,150,000**

14. **12/2004** \$ **1,150,000**

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5		6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A	6800	hrs	\$ 170,006	1,553	\$ 38,828	\$ 2,052	8,353	\$ 210,886	1	
2	Licensed Speech and Language Development Therapist	10A	988	hrs	24,700	971	24,271	616	1,959	49,587	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10A	5460	hrs	136,503	947	23,666	6,001	6,407	166,170	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39		# of prescrpts				144,825		144,825	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify): P/S X-Ray,Lab	10a,39,Col.3					25,670			25,670	13	
14	TOTAL				\$ 331,209	3,471	\$ 112,435	\$ 153,494	16,719	\$ 597,138	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (111,067)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (95,568))	642,119		3
4	Supply Inventory (priced at)	7,333		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,731		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 541,116	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,375,740		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	907,179		16
17	Accumulated Depreciation (book methods)	(260,232)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,022,687	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,563,803	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,216	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	263,346		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,890		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	53,602		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 545,054	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,733,736		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,733,736	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,278,790	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,285,013	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,563,803	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,045,395)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,045,395)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,349,553)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,349,553)	17
	B. Transfers (Itemize):		
18	Change In Interdivision	3,679,961	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3,679,961	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,285,013	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,456,065	1
2	Discounts and Allowances for all Levels	(1,400,142)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,055,923	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,420,303	6
7	Oxygen	(1,692)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,418,611	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	914	12
13	Barber and Beauty Care	22,770	13
14	Non-Patient Meals	543	14
15	Telephone, Television and Radio	3,030	15
16	Rental of Facility Space		16
17	Sale of Drugs	145,200	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,909	19
20	Radiology and X-Ray	3,851	20
21	Other Medical Services	2,767	21
22	Laundry	678	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 210,662	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(4,896)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (4,896)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	1,417	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,417	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,681,717	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	903,657	31
32	Health Care	2,577,692	32
33	General Administration	1,551,695	33
	B. Capital Expense		
34	Ownership	1,662,956	34
	C. Ancillary Expense		
35	Special Cost Centers	335,270	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,031,270	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,349,553)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,349,553)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **MANORCARE OF HIGHLAND PARK**# **0045369**Report Period Beginning: **01/01/03**

Ending:

12/31/03**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,556	1,682	\$ 53,102	\$ 31.57	1
2	Assistant Director of Nursing	2,520	2,724	80,248	29.46	2
3	Registered Nurses	21,495	23,234	608,792	26.20	3
4	Licensed Practical Nurses	7,956	8,600	174,163	20.25	4
5	Nurse Aides & Orderlies	63,625	68,773	813,104	11.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	11,197	12,127	326,673	26.94	7
8	Rehab/Therapy Aides	449	487	4,536	9.31	8
9	Activity Director	7,449	8,048	95,916	11.92	9
10	Activity Assistants					10
11	Social Service Workers	3,698	4,004	74,059	18.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,120	23,859	262,973	11.02	15
16	Dishwashers					16
17	Maintenance Workers	2,073	2,182	41,613	19.07	17
18	Housekeepers	11,346	12,270	127,650	10.40	18
19	Laundry	2,166	2,341	23,261	9.94	19
20	Administrator	2,271	2,080	98,255	47.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,708	16,261	299,647	18.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	270	292	3,653	12.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,899	188,964	\$ 3,087,645 *	\$ 16.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	19,042	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,042		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,506	\$ 65,666	5,10,3	50
51	Licensed Practical Nurses	15	312	5,10,3	51
52	Nurse Aides	43	513	5,10,3	52
53	TOTAL (lines 50 - 52)	2,565	\$ 66,491		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Theresa Smelser	Administrator	0	\$ 98,255	Workers' Compensation Insurance		\$ 77,175	IDPH License Fee		\$ 8,133		
				Unemployment Compensation Insurance		23,732	Advertising: Employee Recruitment		38,859		
				FICA Taxes		223,459	Health Care Worker Background Check (Indicate # of checks performed <u>71.04</u>)		1,776		
				Employee Health Insurance		195,812	Dues & Subscriptions		5,307		
				Employee Meals			Association Dues		9,767		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising		15,104		
				401K / SMSP Match		10,693	Marketing/Lecture		2,100		
				Other Employee Benefits		4,722					
				Employee Uniforms		46					
				Employee Vaccinations			Less: Non-Allowable Assoc. Dues		(2,943)		
				Home Office Allocation		57,478	Less: Public Relations Expense	(
							Non-allowable advertising		(15,104)		
							Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 98,255				TOTAL (agree to Sch. V, line 20, col. 8)	\$	62,999		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)							
Description			Amount			\$ 593,117					
Home Office Allocation			\$ 415,093								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 415,093								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Van Ostrand & Elvidge Kelley	Legal Fees		\$ 1,189	N/A		\$	Out-of-State Travel		\$		
Footo, Meyrs, Mielke & Flowers	Legal Fees		2,062								
Special Consultant	Admin		8,982								

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$9,767
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,936 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 117,713
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 543
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.